Controlled Medicines Agreement

I, <<Patient_Full_Name>> agree to the following expectations and understand that if I do not follow these expectations that my treatment will be stopped.

1. I understand that I am being prescribed strong medicine(s) and I have been informed of the common side effects which I will promptly report to my prescribing physician.

2. I know I may become dependent or addicted to the medicine(s). I agree to take the medicine(s) exactly as prescribed and to not suddenly stop, increase or decrease the medication without my physician's guidance due to possible life threatening withdrawal symptoms and /or overdose.

3. I must avoid driving or operating machinery as the medicine(s) may make me sleepy or dizzy, and I also realize that alcohol may change the effects of my medication if it is a medication used for pain, anxiety or sleep.

4. I understand that the prescription will not be refilled early and I am responsible for properly taking and safeguarding the medicine(s). Any signs of misuse of the medication will be reason for the prescriber to discontinue prescribing for me.

5. I agree that the medicine(s) will be prescribed for no more than 30 days at a time (for chronic pain meds) by my physician or one covering for him/her and at the time of my office appointment.

6. I agree to show up for my appointments at the office regularly as advised; these will be at least every 6 months.

7. The treatment will be stopped if I am found not to be taking the prescribed medicine as directed by my physician, or if I take any similar medication without my physician's knowledge, or if I attempt to fill my prescription at an ER or by another provider. If it becomes necessary for me to receive a medication from an ER physician I must notify my primary physician the next business day.

8. I understand that no refills will be made on evenings, weekends or holidays or by phone or fax. I may be asked to come to the office to pick up a printed prescription and I further understand that I must allow 3 business days for processing of any refills.

9. I will use only the following pharmacy to fill all my prescriptions:_____. If this changes at any time, I must notify my physician by the next business day.

10. I understand that lost, stolen or damaged medications will not be replaced.

11. I agree not to sell, lend, or share my medicine(s) with any other person.

12. I agree to submit my urine and/or blood specimen for drug tests at any time.

13. I agree to participate in tests, other treatments such as exercise, physical therapy, behavioral therapy, rehab, or evaluation by other specialists recommended by my provider.

14. I am not pregnant at this time and will avoid becoming pregnant while taking this medication.

15. I agree that I am currently not using illegal drugs and have never been involved in the sale, illegal possession, diversion or transport of a controlled substance.

<<Patient_Full_Name>> Signature:_____
<<mmm_dd,_yyyy>>

Witness Name:_____ Signature:_____
<<mmm_dd,_yyyy>>

<<Provider_Full_Name>>Signature:_____
<<mmm_dd,_yyyy>>